

Coyle, Briege

From: Mulhern, Kevin
Sent: 29 March 2004 16:34
To: Gowdy, Clive; Campbell, Dr Henrietta; Burne, Alison
Cc: Gardner, Jeremy; Moore, Martin; Shannon, Colm
Subject: FW: Dr H Campbell-The Issue-25 Mar 2004



DHSSPS-Dr H
Campbell-The Issue..

-----Original Message-----

From: Young, Jennifer [mailto:Jennifer.Young@ni] [REDACTED]
Sent: 29 March 2004 16:05
To: 'Kevin Mulhern'
Subject: Dr H Campbell-The Issue-25 Mar 2004

<<DHSSPS-Dr H Campbell-The Issue-25 Mar 2004.doc>>

Programme	UTV's "The Issue"
Date & Time	25 March 2004 – 11.21am
Subject	Death of Lucy Crawford
Prepared By	Typist: [REDACTED] MMU: PF/KC

FEARGHAL McKINNEY

Joining us the Chief Medical Officer, Dr Henrietta Campbell. You have ultimate responsibility for learning the lessons from untoward events in hospitals, that's a damning indictment, what happened to Lucy?

DR HENRIETTA CAMPBELL

Well firstly Fearghal, I need the opportunity to say how deeply tragic these 2 incidents have been, and myself and everyone else in the Health Service deeply regrets the death of any child. But for these 2 beautiful children to have died, lessons have been learned, lessons continue to be learned, but sympathy for the families has to be utmost.

FEARGHAL McKINNEY

It does, but what happened to Lucy?

DR HENRIETTA CAMPBELL

With Lucy, we saw the first test of what was a very rare occurrence, written up in the medical journals only recently, and the outcome of Lucy's death, the lessons not learned early enough to prevent a second death.

FEARGHAL McKINNEY

But you're not recognising the coroner's results in that statement, because the coroner said that, Lucy Crawford died as a result of mal-administration of fluids, it was the wrong fluid and it was too much.

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DR HENRIETTA CAMPBELL

At that time in the year 2000, the fluids being used in every paediatric unit in Northern Ireland, and in most paediatric units throughout the UK, were the fluids that were being given to Lucy. What we now know is that from a few cases written up in the medical journals, in some children, a very few children, but enough to be left ...

FEARGHAL McKINNEY

That's ignoring, I'm sorry, that's ignoring what the coroner said. The coroner said the doctor gave the wrong liquid at the wrong dose, nothing to do with how the victim responded to it, that's what happened, isn't it, that's what happened to Lucy?

DR HENRIETTA CAMPBELL

In retrospect, yes. What was being used at that time was in common practice throughout the UK and wider afield ...

FEARGHAL McKINNEY

You're now accepting fully what the coroner said, when did you learn that this untoward event had happened?

DR HENRIETTA CAMPBELL

We learned about this untoward event in Lucy's death when Rachel died, and the coroner saw that he had 2 cases being presented to him, which looked similar in terms of the tragic outcome ... please let me finish. So the coroner noticing a pattern, reported those 2 cases to me ...

FEARGHAL McKINNEY

So without the death of Rachel Ferguson, you wouldn't have known about the death of Lucy Crawford, an untoward event that you should have known about and you wouldn't have known about it, but for the death of Rachel Ferguson.

DR HENRIETTA CAMPBELL

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We had no system within the Health Service at that time for the reporting of all deaths of children.

FEARGHAL McKINNEY

So there's no system for telling how, for telling you how a trust of this Lakeland Trust, mal-administered fluids to a child that led to that's child's death and you don't know about it? Who's fault is that, who's accountable for that, are you accountable, or the Sperrin Trust accountable?

DR HENRIETTA CAMPBELL

Within the Health Service it is recognised that until quite laterally, there has been no system throughout the UK, please Fearghal I need to finish this important point, throughout the UK, there has been no system of gathering together evidence from untoward incidents which are very rare, but which together across the UK begin to show a pattern and begin to show that systems need to change.

FEARGHAL McKINNEY

The rarity in this was the administration of the dose and not the victim. Why didn't you learn, you are the Chief Medical Officer, ultimately responsible for learning the lessons from this death, and you're telling me here tonight that you didn't know about an untoward event, because the systems failed, is that good enough?

DR HENRIETTA CAMPBELL

The rarity in this event and you do have to return to the medicine, the physiology behind these 2 events, you know, you must let me finish. There's no point my coming here and just being shouted at. The public have a right to know what the issues are. The rarity in these 2 events was the abnormal reaction which is seen in a very few children to the normal application ...

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FEARGHAL McKINNEY

Sorry, because you seem to be ignoring and you're going back on what you accepted a moment ago, do you accept fully the coroner's findings? The coroner said it was the wrong dose and too much, now you're backtracking on that, do you accept the coroner's findings?

DR HENRIETTA CAMPBELL

In the knowledge of the evidence which has been in the medical journals over the past 4 years since Lucy's death, yes that is true, but in the light of what was known in the medical community throughout the whole of the UK in the year 2000, when poor Lucy died, there were very few people who would have known what was going wrong, apart from one or two experts who had begun to notice the very abnormal reaction in certain children.

FEARGHAL McKINNEY

Yes, and of course when the Trust went to investigate it, you would have thought that they might have identified, wouldn't you, the rarity as you described it, but instead they produced a review which didn't point the finger at mal-administration, which effectively, and technically covered up this death, because you would never have found out about it and you've got ultimate responsibility and you still didn't learn until Rachel Ferguson died.

DR HENRIETTA CAMPBELL

From the papers which the coroner has sent to me, and which I'm now beginning to read carefully, and which the coroner has been sharing with me, we've been discussing these issues. The coroner and I together, both recognise that these 2 tragic deaths brought together as a pattern, then allowed us, to put two and two together and to recognise that there were some strange but rather unique features afoot which needed to be taken into

FEARGHAL McKINNEY

But the Sperrin Lakeland Trust didn't conclude that, the Sperrin Lakeland Trust didn't tell you, the Sperrin Lakeland Trust in Lucy Crawford's case kept it to itself, and you didn't know. Now, should somebody in the Health Service in Fermanagh have responsibility for that, should Hugh Mills consider his position in relation to that?

DR HENRIETTA CAMPBELL

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Going back to the year 2000 it would not have been unusual for a doctor or a group of experts not to have recognised what happened to Lucy. It is easier to do that in the knowledge of what has been presented to us through the medical journals in the last 4 years.

FEARGHAL McKINNEY

But you are ignoring what I pointed out to you, that you wouldn't have known and the Trust was certainly not telling you anything about Lucy Crawford's death, and yet you now recognise it as an untoward event, an event that the population in Northern Ireland should learn lessons from, and you haven't been able to learn those lessons, and didn't learn them in the last 3 or 4 years, do you accept that fully?

DR HENRIETTA CAMPBELL

Oh I absolutely agree that if we'd had in place a system for the reporting of all deaths to some central source, untoward deaths that we could have begun to learn lessons earlier. That brings me back to a point which I made earlier, the systems were not in place throughout the Health Service, they do need to be in place UK wide to pick up the very rare issues, but that is being addressed, the National Patient Safety Agency is now in place for early indications of untoward incidents, such as this.

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